TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Texas Mutual Insurance Co

MFDR Tracking Number
M4-16-3556-01

Carrier's Austin Representative
Box Number 54

MFDR Date Received
July 29, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "…she has notes of the patient claim case that out of network for Doctors Hospital at Renaissance has been approved for the visit and is god [sic] for 1 year."

Amount in Dispute: $597.87

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor had out of network approval to treat the claimant for the disputed dates. Texas Mutual paid the requestor $4,356.79 for the treatment provided. Texas Mutual believes no additional payment is due. Texas Mutual claim (claim number) is a participant in the Texas Star Network. (Attachment) Rule 133.305(a)(5) defines a medical fee dispute as one that involves "…an amount of payment for non-network health care…The dispute is resolved by the division pursuant to division rules, including §133.307 of this title (relating to MDR of Fee Disputes)…" Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

Response Submitted by: Texas Mutual Insurance

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 2 – 18, 2016	Outpatient Hospital Services	$597.87	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for services provided in

outpatient hospital services.

3. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 18 – Exact duplicate claim/service
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - 97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 45 – Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
   - 370 – This hospital outpatient allowance was calculated according to the APC rate plus a markup
   - 616 – This code has a status Q APC indicator and is packaged into other APC codes that have been identified by CMS
   - 617 – This item or service is not covered or payable under the Medicare outpatient fee schedule
   - 618 – The value of this procedure is packaged into the payment of other services performed on the same date of service
   - 723 – Supplemental reimbursement allowed after a reconsideration of services
   - 724 – No additional payment after a reconsideration of services
   - 725 – Approved non network provider for Texas Star Network claimant per Rule 1305.153(c)
   - 767 – Paid per O/P FG at 200%: Implants not applicable or separate reimbursement (with cert) not requested per Rule 133.403(g)
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time
   - W3 – In accordance with TDI-DWC Rule 134.804, this bill has been identified as a request for reconsideration or appeal
   - 224 – Duplicate charge

Issues

1. Is the respondent's position supported?
2. What is the applicable fee pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. The respondent states in their position, "Because this is network healthcare Rule 133.307 does not apply. Rather, the requestor should access Complaint Resolution through Coventry Workers' Comp Services."

   The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation is to apply Texas Labor Code statutes and rules, including 28 TAC §133.307, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305. In particular, TIC §1305.153 (c) provides that "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

   Texas Insurance Code Section 1305.006 states,

   > An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:
   >
   > (1) emergency care;
   >
   > (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and

(3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section 1305.103.

Review of the submitted documentation finds that respondent acknowledged network approval via the Explanation of Benefits reason code by stating "725 – Approved non network provider for Texas Star network claimant per Rule 1305.153(c)." The Division finds that the EOB reason 725 is sufficient evidence to support the required referral for out-of-network to treat the injured worker was obtained. For this reason, the services in dispute will be reviewed per the applicable Division Rules and Fee Guidelines.

2. The services in dispute are for outpatient hospital services and are therefore subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided..." The applicable Medicare payment policy may be found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   In order to calculate the correct Division fee guideline, stakeholders should be familiar with the main components in the calculation of the Medicare payment for OPPS services which are:

   - **How Payment Rates Are Set**, found at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/HospitalOutpaysysfctsht.pdf,
     - *To account for geographic differences in input prices, the labor portion of the national unadjusted payment rate (60 percent) is further adjusted by the hospital wage index for the area where payment is being made. The remaining 40 percent is not adjusted.*
   - **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum D1.
   - **APC payment groups** - Each HCPCS code for which separate payment is made under the OPPS is assigned to an ambulatory payment classification (APC) group. The payment rate and coinsurance amount calculated for an APC apply to all of the services assigned to the APC. A hospital may receive a number of APC payments for the services furnished to a patient on a single day; however, multiple surgical procedures furnished on the same day are subject to discounting. The relevant payment amount for each APC may be found at: www.cms.gov, Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Annual-Policy-Files, Addendum B. These files are updated quarterly.

   28 Texas Administrative Code §134.403 (f) states in pertinent part,

   The reimbursement calculation used for establishing the MAR shall be the Medicare facility specific amount, including outlier payment amounts, determined by applying the most recently adopted and effective Medicare Outpatient Prospective Payment System (OPPS) reimbursement formula and factors as published annually in the Federal Register. The following minimal modifications shall be applied.

   (1) The sum of the Medicare facility specific reimbursement amount and any applicable outlier payment amount shall be multiplied by:

   (A) 200 percent;

The service in dispute is calculated as follows:

Submitted code	Status Indicator	APC	Payment Rate	Unadjusted labor amount = APC	Geographically adjusted labor amount = unadjusted labor amount x	Non labor portion = APC payment rate x 40%	Medicare facility specific reimbursement (geographically adjusted labor)	Maximum Allowable Reimbursement

				payment x 60%	annual wage index/0.7989		amount + non labor portion)	
G0277	S	5061	$107.71	$107.71 x 60% = $64.63	$64.63 x 0.7989 = $51.63	$107.71x 40% = $43.08	$51.63 + $43.08 = $94.71	$94.71 x 200% = $189.42
							Total	$189.42

The claim lines in dispute have varied units of service and is calculated as follows:

- Procedure code G0277, date of service February 2, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.
- Procedure code G0277, date of service February 3, 2016, with an allowable of $94.71 per unit multiplied by 3 units is $284.13. This amount multiplied by 200% yields a MAR of $568.26.
- Procedure code G0277, date of service February 5, 2016, with an allowable of $94.71 per unit multiplied by 3 units is $284.13. This amount multiplied by 200% yields a MAR of $568.26.
- Procedure code G0277, date of service February 8, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.
- Procedure code G0277, date of service February 10, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.
- Procedure code G0277, date of service February 11, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.
- Procedure code G0277, date of service February 15, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.
- Procedure code G0277, date of service February 16, 2016, with an allowable of $94.71 per unit multiplied by 3 units is $284.13. This amount multiplied by 200% yields a MAR of $568.26.
- Procedure code G0277, date of service February 17, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.
- Procedure code G0277, date of service February 18, 2016, with an allowable of $94.71 per unit multiplied by 2 units is $189.42. This amount multiplied by 200% yields a MAR of $378.84.

The remaining services in dispute were reviewed as follows:

- Procedure code 82962, date of service February 3, 2016, has status indicator Q4. Status indicator “Q4” designates packaged APC payment if billed on the same claim as a HCPCS code assigned status indicator “J1,” “J2,” “S,” “T,” “V,” “Q1,” “Q2,” or “Q3.” Review of the services finds G0277 has an “S” status indicator therefore code 82962 is packaged, no additional payment is recommended.
- Procedure code A9270, date of service February 3, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, date of service February 5, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, February 8, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.

- Procedure code A9270, date of service February 10, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, date of service February 11, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, date of service February 15, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, date of service February 16, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, date of service February 17, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.
- Procedure code A9270, date of service February 18, 2016, has status indicator E denoting non-covered items, codes or services that are not paid by Medicare when submitted on outpatient claims. Reimbursement is not recommended.

3. The total allowable reimbursement for the services in dispute is $4,354.18. This amount less the amount previously paid by the insurance carrier of $4,375.07 (less $18.28 interest) or $4,356.79 leaves an amount due to the requestor of $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		September 20, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.